THE UNIVERSITY OF ALABAMA®

Psychology Clinic
PO Box 870356
200 Hackberry Lane, McMillan Hall
Tuscaloosa, AL 35487
Phone: (205) 348-5000

The University of Alabama Psychology Clinic
INDIVIDUAL/FAMILY COVID-19 DISCLOSURE AND ACKNOWLEDGMENT

CLIENT FORM: This should be initialed and signed by ALL individuals and family members (14 years or older) who are attending/visiting the Psychology Clinic.

Please read and initial each statement below.

1. _____ **Restricted Access to Facility**. I understand that during this COVID-19 Public Health Emergency I will NOT be permitted to enter The University of Alabama Psychology Clinic or their premises (hereinafter referred to as "Clinic") until a student-therapist walks me to my Clinic room. I understand that this procedure change is for the safety of all persons present in the Clinic and to limit, to the extent possible, everyone's risk of exposure.

2. _____ **Adult Handwashing, Face Mask, Social Distancing**. I understand that when I enter the Clinic, I MUST use hand sanitizer upon entering the Clinic (located in main lobby of McMillan) or wash my hands with soap and water (restrooms are located next to Clinic entrance), and wear a mask that completely covers my nostrils and my mouth. While in the Clinic I must practice social distancing and remain 6 feet from all other people, excluding my own family members or in therapy rooms where room size does not allow for a 6-foot distance.

3. _____ **Symptom Free**. I understand that to enter upon the Clinic premises myself and family must be free from COVID-19 symptoms. Symptoms on the Center for Disease Control (CDC) website may change and are not all inclusive, but include the following:

Fever of 100.4 degrees Fahrenheit or higher	Chills
Cough	Shortness of breath or difficulty breathing
Fatigue	New loss of taste or smell
Sore throat	Muscle or body aches
Headache	Congestion or runny nose
Nausea or vomiting	Diarrhea

While we understand that many of these symptoms can also occur in non-COVID-19 related conditions we must proceed with an abundance of caution during this Public Health Emergency. Typically, a person develops symptoms 5 days after being infected, but symptoms can appear between 2-14 days after exposure to the virus. Please take these symptoms seriously.

4. _____ **Mandatory Notification to Therapist.** In the event I or my family member (a) test positive for COVID-19; (b) show any of the CDC recognized symptoms of COVID-19, including those

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mentioned in paragraph three (3) above; (c) are advised to self-quarantine or self-isolate by a public health official or medical provider, including any medical professional employed by or acting on behalf of UA; or (d) become aware that I or my family member has been in close contact to a person that exhibits any of the symptoms identified by the CDC, including those listed in paragraph three (3) above, is advised to self-isolate or quarantine, has tested positive, or is presumed positive for COVID-19, I will immediately notify my therapist and resume teletherapy sessions.

5. _____ **Acknowledgement**. I understand that there is an inherent risk of exposure to COVID-19 in any place where people are present, including this Clinic. I understand that myself/family, while present in the Clinic each day, maybe in contact with children, families, students, and employees who are also at risk of community exposure. I understand that COVID-19 is an extremely contagious disease that can lead to severe illness or even death. I understand that no list of restrictions, guidelines or practices will remove 100% of the risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I further understand that despite the efforts being made by the University and this Clinic to limit such exposure or infection, my and/or my family member's presence in this Clinic may nonetheless expose my family and/or myself (and ultimately other members of our household) to a risk of contracting COVID-19. I acknowledge that even if my family and I, and UA and this Clinic, all use reasonable care in our actions, there remains a risk that I/my family may become exposed to or infected with COVID-19 while we are in or on this Clinic's premises. I also understand that I/my family members play a crucial role in keeping everyone in the Clinic safe and reducing the risk of exposure by following the practices referenced herein. I understand that any failure to follow the practices referenced herein may result in my removal from onsite therapeutic services.

I certify that I have read, understand, and agree to comply with the provisions listed herein. I acknowledge that failure to act in accordance with the provisions listed herein, or with any other policy or procedure outlined by the Clinic will result in my/my family member's possible dismissal from the program.

Print Client and/or Guardian Name(s): _____

Client/Guardian Signature: _____
Date

Client/Guardian Signature: _____
Date

_____ _____
Witness Signature Date